Original Research

Role conflicts of physicians and their family members: rules but no rulebook

Frederick M Chen
Agency for Healthcare Research and Quality
Center for Primary Care Research
6010 Executive Blvd, Ste 202
Rockville, MD 20852

Chris Feudtner
Child Health Institute
Department of Pediatrics
University of Washington School of Medicine
Seattle, WA

Lorna A Rhodes
Robert Wood Johnson Clinical Scholars Program
and
Department of Anthropology
University of Washington School of Medicine

Larry A Green
The Robert Graham Center
Policy Studies in Family Practice and Primary Care
Washington, DC

Correspondence to:
Dr Chen
fchen@ahrq.gov

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ABSTRACT ● **Objectives** To elucidate the difficulties physicians have when a family member becomes ill and to elicit their underlying causes. ● **Design** Using a key informant technique, we solicited chairs of family medicine departments for their experiences with the health care provided to seriously ill family members. We then conducted in-depth, semistructured telephone interviews that were then transcribed, coded, and labeled for themes. ● **Subjects** 8 senior family physicians whose parents had experienced a serious illness within the past 5 years. All of the subjects reflected on experiences stemming from their fathers' illness. ● **Results** These physicians faced competing expectations: at an internal level, those of their ideal role in their family and their ideal professional identity; and at an external level, those originating from other family members and from other physicians. Reconciling these conflicting expectations was made more difficult by what they deemed to be suboptimal circumstances of the modern health care system. ● **Conclusions** Conflicting rules of appropriate conduct, compounded by the inadequacies of modern health care, make the role of physician-family member especially challenging. The medical profession needs a clearer, more trenchant understanding of this role.

Physicians have long been discouraged from providing medical care for their own family members. Percival's *Medical Ethics,* published in 1803, argued for the separation of professional and personal identities in the care of family members.[1] The most recent American Medical Association guidelines from the Council on Ethical and Judicial Affairs state, "physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient."[2] Studies have shown that the influence of a physician-family member may result in increased diagnostic testing and costs; in one survey, a third of physicians reported observing another physician "inappropriately involved" in a family member's care.[3-5]

Despite these injunctions, physicians may feel compelled to become involved in the care of family members, especially when their well-being appears jeopardized by a health care system that is remarkably complex and prone to error.[6-11] The prevailing ethical precepts may not be morally informative when physician-family members confront real-world dilemmas.[12-15]

To understand the subtleties of the challenges that physician-family members face, we solicited chairs of academic departments of family medicine for their experiences when their own parents required medical care. These senior family physicians—committed to the values of continuous coordinated care and skilled in navigating the complexities of medical care—offered insights into physicians' conflicts when family members become ill.

Summary points

- Physician-family members face competing personal and professional expectations from both internal and external sources
- Reconciling these competing expectations is made more difficult by destabilizing aspects of the modern health care system
- Physicians can prepare for possible identity conflicts by considering their personal expectations
- Physicians and educators should be aware of the conflicting expectations and dilemmas that physicians face when family members become ill

METHODS

After obtaining approval from the University of Washington School of Medicine's Human Subjects Review Committee, we solicited the chairs of every academic family medicine department in the United States by e-mail using addresses obtained from the Association of Departments of Family Medicine, Leawood, KS. The responding physicians were eligible to participate if either of their parents had a serious or terminal illness episode within the past 5 years. All physicians provided verbal and written consent to participate in the study; confidentiality was protected by the removal of personal identifiers from the transcripts and the avoidance of reporting identifiable details of the individual cases.

One of us (F M C) conducted initial in-depth, semistructured interviews of between 45 and 60 minutes with each of the study physicians using a field-tested interview format.[16] The interview began with the physician narrating his or her parent's illness and answering specific questions about the physician-family member's experience. All interviews were conducted by telephone and were recorded and the tapes transcribed. Two of us (F M C, L A G) independently read, coded, and labeled the transcripts for themes using an open-coding technique.[17] After mutual themes were identified by the reviewers' analyses, the study physicians were interviewed again by telephone for 15 to 20 minutes, with the tapes again being recorded,

transcribed, and analyzed. The goal of these second interviews was, through participant feedback, to validate and clarify themes that had emerged during the initial analysis.[18,19]

Eight family physicians agreed to participate, met the eligibility criteria, and consented to be interviewed. All were department chairs except for 1 who was a senior faculty member referred to the study by a department chair. The study participants, 2 of whom were female, ranged in age from 43 to 54 years, were distributed across the United States, and had practiced medicine for a mean of 19.4 years. Although the physicians had been solicited for the illness episodes of either parent, all related experiences with their fathers.

RESULTS

The physicians found the role of physician-family member profoundly challenging. Through their training and position, they recognized the inherent contradictions of being both professional and personal caregivers, but still felt unprepared for the ethical dilemma that they encountered. Physician A: "Nothing in your career prepares you for being a concerned family member and a person who has a position of responsibility within the system. It's just hard, and there's no rulebook."

The role conflict of physician-family members is a complex balance of internal and external influences that are either personal or professional in nature. Internally, physicians have an identity and responsibilities that are balanced between their familial and professional roles. Externally, the distinct familial expectations of the physician-family member's role contend with the expectations of other physicians and the health care system. The experiences of the study physicians illuminate these 4 sets of expectations and demonstrate how physicians must struggle to interpret these rules—without the benefit of a comprehensive rulebook (figure).

Internal: "devoted family member"

The personal responsibility to one's family is deep-seated, and a person's behavior is affected by his or her familial identity and relationships. These physicians thought that their role during their fathers' illnesses should be primarily that of a family member. Physician B: "Even though you are terrified, angry, and sad, your role in the family is to reassure them."

Although the physicians were wary of becoming involved in their fathers' medical care, they found that even their personal identity as son or daughter was changed by their professional knowledge. Another physician [physician C] acknowledged the difficulty of balancing personal and professional roles: "I learned some pretty valuable lessons about the difficulty of trying to care for family members, as the doctor and as the son. It was extraordinarily stressful. I tried to dissociate myself from the medical knowledge. But I just couldn't do that."

Internal: "an ideal physician"

Physicians strive to balance informed advocacy with dispassionate professionalism, both of which are prized in medical practice. As family members, these physicians were intimately knowledgeable about their fathers' health conditions, medical histories, and preferences for care. As family physicians, they understood the value of emotional distance and objectivity in medical decision making. Physician C:

> You come with the mindset that you want to be a family member, but the flip side is that you know so much about how the system does and doesn't work that you feel compelled to become more involved. . . . you have more knowledge about how that person in your family lives than the clinicians do, so you feel compelled to get that information across. It is really a terrible 'Catch 22'.

External: expectations of families

Family members often expect a high degree of involvement—uncomfortably high—from their physician-relatives. The physicians in our study had long recognized this aspect of the relationship with their families. Physician D:

> My aunts and uncles and cousins tended to call me for [medical] advice, and I always found that somewhat uncomfortable. My discomfort was never in providing information; it was around having some objectivity in listening to what they were telling me.

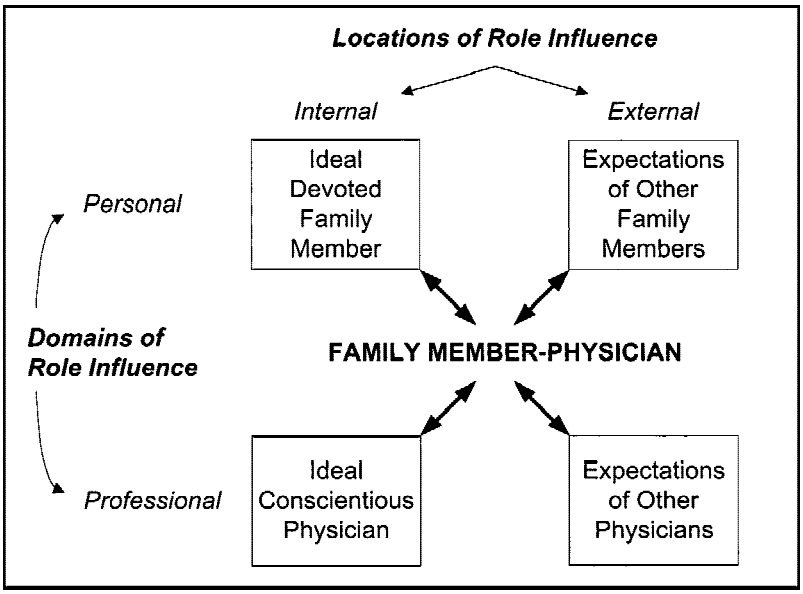
Generally, the physicians were most comfortable in the role of information providers and were prepared to handle this component of the conflict. Physician E:

> My parents knew that end-of-life care is one of the things that I do a lot of in my own practice. So they couldn't divorce themselves from that knowledge. I ended up finding a comfort level of trying to be a good advisor and help with some of those medical issues, but not doing any of it directly myself.

The physicians also thought that an underlying anxiety compelled their families to turn to them for help. Physician F: "My brother's statement was, 'I don't see how any family can go through something like this, if there's not a family member that's a physician.' "

External: expectations of other physicians

Although these physicians had anticipated their families' demands, they were surprised to find that other physicians



The conflicting expectations that physician-family members face

also welcomed and even expected their participation. Indeed, they were often asked by other physicians to take part in their parent's care. One physician's father was diagnosed with an aortic aneurysm by his urologist. Physician G:

> Instead of referring him to a surgeon in town, or back to his physician, the urologist told them to call me. I didn't know what they were talking about. So it was a really stressful time to figure out what the heck was going on. Most physicians don't say, "Go call your son to take care of this." I just thought it was inappropriate that the urologist referred this to me as the son who happened to be a physician.

At other times, the physicians' dilemma was made even more difficult because they knew other physicians were suspicious of intrusive physician-family members. This bias created a conflicting set of external professional expectations. Physician E: "I'm awfully aware of having doctor-relatives call because of their parents, kids, or whatever. I find it's usually obnoxious. So I would be very slow to play that role."

Physicians thought that health care providers were often conflicted about how to treat them. Physician A:

> They expect you to follow up on lab and stuff. I'm not kidding. And so they're really conflicted about how to treat you as a colleague/family member. Somehow things fall through, and there's an expectation that you'll pick them up. And try as I might, to be just the family member, it's almost as though you're sucked into it on different levels—from the attending physicians on down.

Maintaining moral balance in unstable circumstances

At some point in their personal narratives, the physicians recognized that they were unable to keep their personal and professional identities separate—indeed, they found that such separation had become morally untenable. Even if they had resisted the pressures from their own families and other physicians, the physicians thought that the changing circumstances of their fathers' care often required their intervention. Physician H:

> I really tried to walk that line of being just a concerned family member, but when things are so blatantly obvious, there is a point when I finally couldn't stay in the bushes anymore. I had to come out. . . . what good is all that training if you can't help your own family?

The technology-centered environment of modern health care destabilizes the already-difficult balance of expectations placed on physician-family members. The physicians were fully aware of the risks their fathers were facing and the difficulty in coordinating optimal care for them; yet, many remained conflicted about having crossed the ethical boundary between physician and family. Physician B: "I think there's this dangerous feeling that we all have of getting in there and doing something."

DISCUSSION

When a family member becomes ill, physicians confront 4 sets of competing and often conflicting expectations. The senior family physicians interviewed for this study each had intended, on learning of his or her father's illness, to adhere to the traditional ethical dictum and maintain separate roles as physician and as family member. For various reasons, they each at some point felt compelled to get involved in their father's care. Their precarious internal and external balance of personal and professional expectations eventually tipped in favor of involvement, with circumstances of care that threatened the fathers' health ultimately making nonintervention morally unacceptable.

Our study findings challenge the utility of time-honored ethical precepts that offer so little assistance to physicians facing real-world dilemmas. Certainly, in a profession that emphasizes detached objectivity and scientific inquiry, the illness of a family member engenders an emotional involvement that can cloud critical thinking and sound judgment. At the same time, deeply personal investment in the patient's well-being can motivate a degree of attention to detail and humanistic thoughtfulness that might otherwise be—sadly—lacking. This total commitment to the welfare of the patient has been undervalued in the formulation of ethical guidelines, whereas the assumption that such personalized care would be provided by the health care system has been overcredited.

Can these conclusions be reasonably generalized? Our sample of physician-family members was small and composed entirely of academic departmental chairs. The pool of possible informants was limited by their unique position and the requirement of having a parent with a recent serious illness episode. This sample was deliberately selected because we were interested in the unique perspective on the physician-family member dilemma afforded by senior physicians familiar with the intricacies of the health care system. Through the process of iterative analysis and second interviews, we uncovered robust themes that accurately represent our sample. Although further generalization must be cautious, the experiences of highly reliable respondents should motivate a broad reassessment of rules governing physician-family member conduct.

We tentatively propose that solutions to the role conflicts for physician-family members involve innovations at both the personal and systemic levels. For example, individual physician-family members might benefit by asking themselves, perhaps with the aid of a trusted colleague, a series of questions intended to clarify their expectations and role conflicts (see box). At a broader level, health care systems might consider providing physicians with an ombudsman or advocate to address their concerns about the care of family members. Professional forums, such as Balint groups, can also address physician-family members' personal responses to these patient care conflicts.[20]

What is needed is a tenable ethical code, one that honestly acknowledges flaws in our current practice of medicine and speaks not in absolutes but provides guidance for difficult decisions. Physicians will always be family members, and the value of their emotional attachments to relatives should not be dismissed. Until the health care system can ensure safer quality care overseen by a reliable patient advocate, physicians and educators should be cognizant of the conflicting expectations, suboptimal care conditions, and consequent dilemmas that physician-family members face.

Addressing physician-family members' role expectations

Ideal family member

- What are my roles in my family?
- What aspects of these roles do I value most?
- How does my medical knowledge change my family role?

Expectations of family members

- What does my family ask of me as a physician?
- How do these requests make me feel?
- How do I behave in response to these requests?
- What would be the consequences of behaving differently?

Ideal physician

- What aspects of my professional identity do I value?
- How does my relationship with my family interact with my professional identity?

Expectations of other physicians

- How do other physicians solicit my involvement?
- How do these solicitations make me feel?
- How do I behave in response to these solicitations?
- What would be the consequences of behaving differently?

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